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Special Article

## Solving the COVID-19 Crisis in Post-Acute and Long-Term Care



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### A B S T R A C T

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Our nation's nursing home industry has been in need of overhaul for decades—a situation made all the more evident by COVID-19. AMDA—The Society for Post-Acute and Long-Term Care Medicine is dedicated to quality in post-acute and long-term care process and outcomes. This special article presents 5 keys to solving the COVID-19 crisis in post-acute and long-term care, related to policy, collaboration, individualization, leadership, and reorganization. Taking action during this crisis may prevent sinking back into the complacency and habits of our pre-COVID-19 lives.

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For post-acute and long-term care (PALTC) providers and other stakeholders, the COVID-19 pandemic has been unlike that of any other sector in the United States. Some of our experiences have been similar to providers in other settings—although amplified and accelerated to a horrifying extent in PALTC—and some have been unique to this patient and resident population, and unique to the various settings of care that compose PALTC. Three months in, we certainly know more about the SARS-COV-2, and COVID-19 disease, than we did in February. We have also learned more about how to respond to outbreaks, and the dire consequences when our responses have been ineffective, or worse, ignored, or blocked by health and/or governmental authorities. We have seen the rapid implementation of national and state policy changes, some well-informed and helpful, others disastrously off the mark. Finally, and perhaps most importantly, we have seen how the COVID-19 crisis has exposed how fundamentally broken our approach to providing care and support to our nation's older adults has become.

From the vantage point of AMDA—The Society for Post-Acute and Long-Term Care Medicine, there are 5 keys to solving the COVID-19 crisis in PALTC. They may not be sufficient to solve the crisis, but they are all necessary elements of a solution.

### Five Keys to Solving the COVID-19 Crisis in PALTC

#### *PALTC Expertise Must Be Included when Policy Is Being Developed That Affects PALTC*

This statement may seem obvious, but we have learned through tragic circumstances that bad policy results when our voice is not at the table. Nursing homes, assisted living communities, and other settings are being asked (or mandated) to take actions that will either harm residents and patients, challenge or expose staff to great risk, or prove simply impossible to implement.

On the other hand, when PALTC expertise is included as policy is being developed, and there is an understanding and acknowledgment of the unique aspects of PALTC, resulting policies are more feasible and supportive. There is a clear line dividing those states whose responses to COVID-19 have included PALTC clinical specialists, operators, and families at the table in these discussions, from those that have not. We have seen examples of the former in Colorado, where regular and open lines of communication between health authorities and nursing home clinical and operational leaders have led to a focus on testing, isolation, cohorting, and admissions from the hospital. In Maryland, where leaders in the health department and acute care, themselves current or previous PALTC clinicians, are working to secure adequate personal protective equipment (PPE) and access to testing. In Ohio, where regular discussions are taking place across the nursing home industry involving PALTC clinical leadership, operators, and public health authorities, clinical leaders have been

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keeping the health department informed of COVID-19 developments and trends in PALTC.

But we have also seen the opposite, such as in New York, where executive orders mandating that nursing homes accept patients with COVID-19,<sup>1</sup> and test all PALTC staff twice weekly,<sup>2</sup> threw nursing homes into chaos, risked higher levels of illness and death among the residents and patients of New York nursing homes, and had to be rolled back or significantly modified when misery and heartbreak became the inevitable consequences. In other states, aggressive advocacy may have prevented similar policies from being implemented or implemented fully.

We are discussing state-level policy here because another thing we have learned is that, in the absence of clear leadership at the Federal level, states, counties, and localities have stepped into the vacuum. We have learned both the clear benefits and obvious limits of our federalist approach to government. States have formed pacts and worked cooperatively and effectively to find solutions to support their citizens' needs, but they have also found themselves in competition with each other and with healthcare organizations, suffered at the mercy of profiteers out to take advantage of supply-chain constraints, and forced to find clarity in a fog of incomplete, unclear, or simply wrong information coming from the Federal government. In the time of COVID-19, even at the highest levels of our government, opinion has been granted equal weight to fact.

#### *Collaboration across Healthcare Sectors Must Become the Norm*

As implied above, in some parts of the country, strong and active collaborative and collegial relationships have been built over years between state and county health authorities and emergency management agencies; nursing home operators, hospitals, consumers, and researchers; and PALTC clinical specialists. In general, in these situations, effective and even innovative solutions have been found to keep people safe and to protect the most vulnerable of our citizens—the frail and medically complex patients and residents of PALTC settings.

We have learned that relationships such as these bring leverage in times of crisis; they bring speed, and an understanding that all stakeholders must work together to find solutions. Most of these relationships have been developed and nurtured over years. It is difficult to develop them on the fly, or while the crisis is upon us. But if the political and cultural will is there, it is possible and worthwhile to do so, as long as historical enmities and distrust toward nursing homes specifically and PALTC in general do not become insurmountable obstacles.

AMDA has worked tirelessly throughout this crisis to help our members in the states work together with their local health departments and acute care colleagues, as well as to build active coalitions to share knowledge as it develops about COVID-19. This is a start, and now local PALTC leaders need to push past the implicit and explicit barriers to make sure their voices are heard.

At best, this hostility to PALTC and our cultural fear and societal revulsion around aging have simply rendered invisible the patient and resident population and the workforce of PALTC. But all too often mere benign neglect is the least of our worries in the time of COVID-19. Increasingly punitive regulatory measures, mounting lawsuits, and the endless drumbeat of negative press stories are assaulting our sector. True, this is not a new phenomenon, but COVID-19 has added rocket fuel to a long-burning fire. More on that below.

We cannot change culture overnight and, possibly, ever, when it comes to nursing homes. But local leaders can recognize the shared plight of vulnerable citizens in need of healthcare services, and the workers who put themselves at risk every day to provide those services. Local leaders can work together to put in place practical, achievable solutions that can ease that plight. And local leaders can access resources and deploy them to the benefit of their stakeholders and constituents. In the time of COVID-19, this may be the best we can do, and it may be good enough.

#### *Do Not Look for One-Size-Fits-All Solutions*

The pattern of COVID-19 spread has been regionally variable, making some state-wide orders ineffective or misplaced. Nursing homes and assisted living communities have very different challenges with COVID-19, as do different counties within the same state. Effective containment responses across all settings of care need to be responsive to local conditions in communities as well as within local PALTC settings.

We have learned that when broad state-wide executive orders are issued by governors without regard to local variability, resources are wasted in areas that have lower need, and are insufficient in areas of higher need. If noncompliance with those executive orders brings with it fines and threats of loss of operating licenses, those orders set up nursing homes for more frustration.

We have seen this misplaced one-size-fits all strategy play out in the push for universal testing of residents and staff in PALTC without regard for an appropriate facility-based strategy. We have also seen it in the requirement for nursing homes to admit patients discharged from hospitals, and in the opposite, in which hospitals are prohibited from discharging patients to nursing homes without knowing their COVID-19 status.

#### *Federal Policy Leadership Must Be Proactive, Not Reactive; and Supportive, Not Punitive*

It has been interesting to observe how, in response to the pandemic, regulators at the Centers for Medicare and Medicaid Services (CMS) have taken down barriers to access on key issues such as telehealth, licensing across state lines, and the 3-day hospital stay. The obvious question here is: Why did it take a pandemic for policymakers to address these long-standing PALTC barriers? And, how can we keep these waivers and flexibilities in place after the COVID-19 crisis abates, and add others? For example, AMDA has advocated for years that CMS publish a registry of all nursing home medical directors, a key role in quality assurance and performance improvement. Especially now, as we battle COVID-19, such transparency is long overdue. Recently, 11 Members of Congress wrote<sup>3</sup> to CMS asking them to do exactly that, but as of this writing, there has been no response.

It is now common knowledge that as the COVID-19 pandemic spread across our country, nursing homes were not prioritized for access to PPE, testing, staff capacity, or other infrastructure support such as alternative bed capacity for cohorting patients and residents. Although some of these constraints have lessened somewhat, nursing homes still have inadequate access to PPE, testing continues to be highly variable, and staff insufficiency, already a problem, has become well-nigh completely unworkable.

In early June, CMS issued additional guidance, suggesting that (1) nursing homes should test all staff and residents weekly but without guidance on how to develop an effective testing strategy or the support to carry this out; (2) nursing homes must report all COVID-19 data to a CDC database weekly, but without adequate time or training for nursing homes to comply with anything other than highly variable and in many cases badly flawed data; and (3) all nursing homes must submit to focused infection control inspections, again with unrealistic deadlines for compliance, putting state survey agencies at risk of losing Federal funds.<sup>4</sup> All of these actions come with immediate threat of punitive fines and other measures including the loss of nursing homes' operating licenses. In light of the extraordinary exigencies nursing homes have faced in this public health emergency, it is difficult to justify measures that are tantamount to setting our homes up to fail—and which implicitly suggest that they themselves may be the cause of COVID-19 in the home.

## The Nursing Home Industry and Regulatory Process Need Massive Restructuring

Our nursing home infrastructure was built 50 years ago, and an initial set of reforms was passed by Congress and signed into law in 1987, designed to improve and standardize nursing home care in light of incidents of elder neglect and abuse that were truly horrifying.<sup>5</sup> After 30 years with no substantive changes, the nursing home regulatory framework was revised in October 2016.<sup>6</sup> But the model of care underlying this framework and the assumptions hidden within it are still woefully out of date.

Life expectancy in the United States in 1970 was age 70 years; today, people live well into their 90s and some 85% of all nursing home residents are over 75 years of age.<sup>7</sup> Most nursing home care was considered “custodial” in the 1970s—long-term care that did not require skilled nursing—and the standardization of skilled nursing facilities did not take place until 1972.<sup>8</sup> Today, most nursing home and assisted living residents have multiple comorbid conditions, and roughly 70% are living with some form of cognitive deficit,<sup>9</sup> including 48% with dementia.<sup>10</sup> Close attention and management of complex drug regimens that often include 10 or 15 different medications is routine.<sup>11</sup> This is a very different patient population from the previous generation.

Some nursing homes are specialized to provide hospital-level care such as ventilator therapy, cardiac rehabilitation, or joint replacement rehabilitation, but the large majority of our 15,400 nursing homes look very much like they did 30 years ago—just with a very different resident population. Staffing levels have stayed fixed, while residents’ needs and medical complexity have increased well beyond this minimal capacity. The buildings themselves are older, with smaller rooms, often 2 to 4 individuals to a room, narrow hallways, and old heating, ventilation, and air conditioning systems. Even when some nursing home organizations have made the investment to renovate their buildings or build new nursing homes with more home-like “neighborhoods,” they must often get past regulatory restrictions that have not kept up with the times.

Unfortunately, the nursing home inspection process—whose intent when Congress passed the Nursing Home Reform Act of 1987 (OBRA) statute was to be a corrective framework to guide nursing homes to implement best practices—has now become punitive. Fines intended as incentives to implement better care are now often weaponized by the CMS, politicians, and survey teams whose inspection processes are more damaging than helpful. And in the era of COVID-19, punitive surveys are not only demoralizing and unhelpful, they are causing nursing home organizations to cut programs or even to consider closing facilities.<sup>12–14</sup> And recent research<sup>15</sup> suggests little connection between the CMS quality measures such as a nursing home’s star rating or prior infection control deficiencies, and the incidence of COVID-19.

### The Bottom Line to Solving the COVID-19 Crisis in PALTC

Abandoning this broken system of care for our nation’s older adults and developing a new system that is responsive to current realities is the only substantive alternative we have. What that new system might look like requires us to answer some fundamental questions about who we are and who we aspire to be as a society.

These questions include.

- Is healthcare a right or a privilege?
- Must the concept of “choice” regarding healthcare include the false “choice” of going without access to adequate healthcare when forced to choose, for example, between buying food and paying the rent, or paying for healthcare?
- What upstream incentives should we put in place as a country to support our citizens before they are old and frail, to take better responsibility for their old age—financially, physically, socially, intellectually, and spiritually?

- How can we at long last reduce or eliminate our cultural bias against aging and the aged? How can we make the aging professions desirable as a career path—rather than being seen by the medical and nursing fields as a last resort for those who experience problems working in other sectors of healthcare?
- And, we cannot ignore the question as to why our system of long-term care is as racially segregated as it is, with 60% of direct care workers being minority, caring for an older adult population that is three-quarters white.<sup>16</sup>

The COVID-19 pandemic has, without question, caused immeasurable heartbreak and misery. It has also called forth some of the most heroic and inspiring acts we have seen among our colleagues and stakeholders. It is now up to us to turn this deadly crisis into something that makes these deaths, this misery, and this heroism contribute to a greater value beyond the immediate: namely, the reinvention of how we provide care and support to our parents and grandparents; how we honor their sacred needs and wishes; how we celebrate and lift up those who have chosen the aging professions as a career; and how we build a just culture of true accountability. Doing so requires a new lens toward policy, collaboration, individualization, leadership, and reorganization. The time for change must be now, while we are still in the terrible grip of this crisis, and before we sink back into the complacency and habits of our pre-COVID-19 lives.

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